

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7203	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2012
NAME OF PROVIDER OR SUPPLIER SPRING CITY CARE AND REHABILITATION CE			STREET ADDRESS, CITY, STATE, ZIP CODE 331 HINCH STREET SPRING CITY, TN 37381		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments Complaint investigation #28366, #28414, #29584, #30370, and #30423 were completed at Spring City Care and Rehabilitation Center on September 12, 2012. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

BSIC11

If continuation sheet 1 of 1